

# A Summer of Exploration

Telegraph Hill Neighborhood Center  
Summer 2012 Registration

May 31st–August 15th

7:30am to 6:00pm (youth must arrive by 10:00am)



Tuition per Full Week Session: \$125

Registration is open to students entering Kindergarten - 6th grade

Please return form  
by Monday, April 30, 2012

- YES, my child will attend Tel-Hi's Summer Program. Please check the weeks that you would like to register for.
- Yes, I will need Early Care from 7:30-10:00am for no extra fee. My child will arrive at around: \_\_\_\_\_ (provide an approximate time).
- No, my child will not attend Tel-Hi's Summer Program. I would like to hold my child's space for the 2012- 2013 After School Academy.

Please check the weeks that you would like to register:

- Welcome to Tel-Hi: May 31st - June 1st (\$50)
- Session 1: Discover Bay Area: June 04-08 (\$125)
- Session 2: Can You Survive the Jungle?: June 11-15 (\$125)
- Session 3: Discover Your Inner Artist: June 18-22 (\$125)
- Session 4: You Too Can Be a Superhero: June 25-29 (\$125)
- Session 5: Into the Deep: July 2-3, 5-6 (\$125)
- Session 6: Up, Up and Away: July 9-13 (\$125)
- Session 7: Get Up and Have Some Fun!: July 16-20 (\$125)
- Session 8: Tel-Hi T.V.: July 23-27 (\$125)
- Session 9: Safari Adventure: July 30-August 3 (\$125)
- Session 10: Cultural Exploration: August 6-10 (\$125)
- Wrap-Up Party!: August 13-15 (\$75)

TOTAL REGISTRATION for all requested weeks: \$ \_\_\_\_\_

- Financial assistance is available for qualifying families. No family will be turned away due to financial difficulties. Please see Jeffrey Ng, ASA Program Manager, for your individual situation.
- Please return this registration form with a \$125 deposit. Your deposit will apply to your *last* week of summer tuition. If your child does not attend a session you registered for with a **15 day cancellation notice**, then you will forfeit your deposit. For families receiving financial scholarships, a \$25 deposit is due.
- Please make checks payable to **Telegraph Hill Neighborhood Center** and mail to Tel-Hi ATTN: Jeffrey Ng, 660 Lombard Street, SF, CA 94133 for all requested weeks.
- Receipt of payment secures your child's spot in the program.
- Please submit payment for the first 6 weeks of summer camp by May 17th, and the last 6 weeks of summer camp by July 1st

Child's Name(s): \_\_\_\_\_

Parent or Guardian's Signature

Date

**TELEGRAPH HILL NEIGHBORHOOD CENTER**

**Summer Camp 2012**

**School-Age (Students *entering* Kindergarten - 6th Grade)**

*REGISTRATION AND RELEASE FORM*

CHILD'S NAME	AGE	CHILD'S BIRTHDATE	GRADE (IN FALL 2012)
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**PERSON(S) RESPONSIBLE FOR CHILD:**

NAME & RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL
NAME & RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL

CHILD'S PRIMARY ADDRESS:	CITY	ZIP CODE
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**EMERGENCY PICK-UP CONTACTS (OTHER THAN THOSE LISTED ABOVE)**

Is this person authorized to pick your child up from Tel-Hi?

NAME & RELATIONSHIP	HOME PHONE	CELL PHONE	<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME & RELATIONSHIP	HOME PHONE	CELL PHONE	<input type="checkbox"/> YES <input type="checkbox"/> NO

**ADDITIONAL PERSONS WHO MAY PICK UP MY CHILD FROM TEL-HI:**

NAME	HOME PHONE	CELL PHONE
NAME	HOME PHONE	CELL PHONE

**MEDICAL INFORMATION AND CONSENT:**

PHYSICIAN AND/OR DENTIST TO BE CALLED IN AN EMERGENCY	MEDICAL PLAN #
ADDRESS	PHONE NUMBER
IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?	
CALL EMERGENCY HOSPITAL _____	OTHER (EXPLAIN): _____
PLEASE LIST ANY ALLERGIES OR SPECIAL MEDICAL CONDITIONS:	

I give permission for my child to participate in all of the Summer Camp 2012 activities at the Telegraph Hill Neighborhood Center (Tel-Hi), including but not limited to field trips. I will assume full responsibility for my child and not hold Tel-Hi staff or volunteers responsible for any damages or accidents that may occur. In case of emergency, I give the staff of Tel-Hi permission to obtain medical help if needed.

Tel-Hi documents program activities which help assist us in obtaining funding to support Tel-Hi programs. In registering for this program, you give Tel-Hi permission to record your child's voice and/or picture for use in television, films, radio, website or printed media to further the mission of Tel-Hi. In signing this agreement I also acknowledge that I have received and agree to abide by the policies and procedures outlined in the ASA Family Handbook.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

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### PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: \_\_\_\_\_

Licensing Office Address: \_\_\_\_\_

Licensing Office Telephone #: \_\_\_\_\_

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

**NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.**

*For the Department of Justice "Registered Sex Offender" database, go to [www.meganslaw.ca.gov](http://www.meganslaw.ca.gov)*

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

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### ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of \_\_\_\_\_, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

\_\_\_\_\_  
Name of Child Care Center

\_\_\_\_\_  
Signature (Parent/Authorized Representative)

\_\_\_\_\_  
Date

**NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.**

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# PERSONAL RIGHTS

## Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
  - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
  - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
  - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
  - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.
  - (6) Not to be locked in any room, building, or facility premises by day or night.
  - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

ADDRESS

CITY

ZIP CODE

AREA CODE/TELEPHONE NUMBER

DETACH HERE

**TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:**

**PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

**ACKNOWLEDGMENT:** I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)

(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

# CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

\_\_\_\_\_ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE  
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

\_\_\_\_\_. THIS CARE MAY BE GIVEN UNDER  
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

\_\_\_\_\_ DATE

\_\_\_\_\_ PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

\_\_\_\_\_ HOME ADDRESS

HOME PHONE  
( )

WORK PHONE  
( )

**CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT**

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME	DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME	DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/MEDICAL EXAMINATION	

**DEVELOPMENTAL HISTORY** (\*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

**PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:**

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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**DAILY ROUTINES** (\*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____
	LUNCH	
	DINNER	

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
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IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*
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PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE

DATE